Number	Category Name	Category Description	HL7 BH Conformance Profile Classification CM = Care Management
	Functional Requirements		
F01	***Identify and maintain a client record***	Key identifying information is stored and linked to the client record. Both static and dynamic data elements will be maintained. A look up function uses this information to uniquely identify the client.	DC \ Care Management
F02	***Manage client demographics***	Contact information including addresses and phone numbers, as well as key demographic information such as date of birth, gender, and other information is stored and maintained for reporting purposes and for the provision of care.	DC \ Care Management
F03	***Manage diagnosis list***	Create and maintain client specific diagnoses.	DC \ Care Management
F04	***Manage medication list***	Create and maintain client specific medication lists- Please see DC.1.7.1 for medication ordering as there is some overlap.	DC \ Care Management
F05	***Manage allergy and adverse reaction list***	Create and maintain client specific allergy and adverse reaction lists.	DC \ Care Management
F06	***Manage client history***	Capture, review, and manage services/treatment, hospitalization information, other information pertient to clients care.	DC \ Care Management
F07	***Summarize health record***		DC \ Care Management
F08	***Manage clinical documents and notes***	Create, correct, authenticate, and close, as needed, transcribed or directly entered clinical documentation.	DC \ Care Management
F09	***Capture external clinical documents***	Incorporate clinical documentation from external sources.	DC \ Care Management
F10	***Generate and record client specific instructions***	Generate and record client specific instructions as clinically indicated.	DC \ Care Management

F11	***Order medication***	Create prescriptions or other medication orders with detail adequate for correct filling and administration.	DC \ Care Management
F12	***Order diagnostic tests***	Submit diagnostic test orders based on input from specific care providers.	DC \ Care Management
F13	***Manage order sets***	Provide order sets based on provider input or system prompt, medication suggestions, drug recall updates.	DC \ Care Management
F14	***Manage results***	Route, manage, and present current and historical test results to appropriate clinical personnel for review, with the ability to filter and compare results.	DC \ Care Management
F15	***Manage consents and authorizations***	Create, maintain, and verify client treatment decisions in the form of consents and authorizations when required.	DC \ Care Management
F16	***Support for standard care plans, guidelines, protocols***	Support the use of appropriate standard care plans, guidelines, and/or protocols for the management of specific conditions.	DC \ Care Management
F17	***Capture variances from standard care plans, guidelines, protocols***	Identify variances from client-specific and standard care plans, guidelines, and protocols.	DC \ Care Management
F18	***Support for drug interaction***	Identify drug interaction warnings at the point of medication ordering	CM \ Clinical Decision Support

F19	***Support for medication or immunization administration or supply***	To reduce medication errors at the time of administration of a medication, the client is positively identified; checks on the drug, the dose, the route and the time are facilitated. Documentation is a by- product of this checking; administration details and additional client information, such as injection site, vital signs, and pain assessments, are captured. In addition, access to online drug monograph information allows providers to check details about a drug and enhances client education.	CM \ Clinical Decision Support
F20	***Support for non-medication ordering***	Referrals, care management	CM \ Clinical Decision Support
F21	***Present alerts for disease management, preventive services and wellness***	At the point of clinical decision making, identify client specific suggestions / reminders, screening tests / exams, and other preventive services in support of disease management, routine preventive and wellness client care standards.	CM \ Clinical Decision Support
F22	***Notifications and reminders for disease management, preventive services and wellness***	Between healthcare service/treatments, notify the client and/or appropriate provider of those preventive services, tests, or behavioral actions that are due or overdue.	CM \ Clinical Decision Support
F23	***Clinical task assignment and routing***	Assignment, delegation and/or transmission of tasks to the appropriate parties.	CM \ Operations Management & Communication

F24	***Inter-provider communication***	Support secure electronic communication (inbound and outbound) between providers in the same practice to trigger or respond to pertinent actions in the care process (including referral), document non-electronic communication (such as phone calls, correspondence or other service/treatments) and generate paper message artifacts where appropriate.	CM \ Operations Management & Communication
F25	***Pharmacy communication***	Provide features to enable secure and reliable communication of information electronically between practitioners and pharmacies or between practitioner and intended recipient of pharmacy orders.	CM \ Operations Management & Communication
F26	***Provider demographics***	Provide a current directory of practitioners that, in addition to demographic information, contains data needed to determine levels of access required by the EHR security and to support the delivery of mental health services.	SS \ Clinical Support
F27	***Scheduling***	Support interactions with other systems, applications, and modules to provide the necessary data to a scheduling system for optimal efficiency in the scheduling of client care, for either the client or a resource/device.	SS \ Clinical Support
F28	***Report Generation***	Provide report generation features for the generation of standard and ad hoc reports	SS \ Measurement, Analysis, Research & Reports
F29	***Health record output***	Allow users to define the records and/or reports that are considered the formal health record for disclosure purposes, and provide a mechanism for both chronological and specified record element output.	SS \ Measurement, Analysis, Research & Reports

F30	***Service/treatment management***	Manage and document the health care delivered during an service/treatment.	SS \ Administrative & Financial
F31	***Rules-driven financial and administrative coding assistance***	Provide financial and administrative coding assistance based on the structured data available in the service/treatment documentation.	SS \ Administrative & Financial
F32	***Eligibility verification and determination of coverage***		SS \ Administrative & Financial
F33	***Manage Practitioner/Patient relationships***	Identify relationships among providers treating a single client, and provide the ability to manage client lists assigned to a particular provider.	SS \ Administrative & Financial
F34	***Clinical decision support system guidelines updates***	Receive and validate formatted inbound communications to facilitate updating of clinical decision support system guidelines and associated reference material	SS \ Administrative & Financial
F35	***Enforcement of confidentiality***	Enforce the applicable jurisdiction's client privacy rules as they apply to various parts of an EHR-S through the implementation of security mechanisms.	INI \ Security
F36	***Data retention, availability, and destruction***	Retain, ensure availability, and destroy health record information according to organizational standards. This includes: Retaining all EHR-S data and clinical documents for the time period designated by policy or legal requirement; Retaining inbound documents as originally received (unaltered); Ensuring availability of information for the legally prescribed period of time; and Providing the ability to destroy EHR data/records in a systematic way according to policy and after the legally prescribed retention period.	INI \ Health Record Information & Management

F37	***Audit trails***	Provide audit trail capabilities for resource access and usage indicating the author, the modification (where pertinent), and the date and time at which a record was created, modified, viewed, extracted, or removed. Audit trails extend to information exchange and to audit of consent status management (to support DC.1.5.1) and to entity authentication attempts. Audit functionality includes the ability to generate audit reports and to interactively view change history for individual health records or for an EHR-system.	INI \ Health Record Information & Management
F38	***Extraction of health record information***	Manage data extraction in accordance with analysis and reporting requirements. The extracted data may require use of more than one application and it may be pre-processed (for example, by being de-identified) before transmission. Data extractions may be used to exchange data and provide reports for primary and ancillary purposes.	INI \ Health Record Information & Management
F39	***Concurrent Use***	EHR system supports multiple concurrent physicians through application, OS and database.	SS \ Clinical Support
F40	***Mandated Reporting***	Manage data extraction accordance with mandating requirements.	SS \ Measurement, Analysis, Research & Reports
F41	***Administrative A/P E.H.R. Support***		
F42	***Administrative A/R E.H.R. Support***		
F43	***Administrative Workflows E.H.R. Support***		
	Security Requirements		
S01	**Security: Access Control**		
S02	**Security: Authentication**		

S03	**Security: Documentation**		
S04	**Security: Technical Services**		
S05	**Security: Audit Trails**		
S06	**Reliability: Backup/Recovery**		
S07	**Reliability: Documentation**		
S08	**Reliability: Technical Services**		
	Interoperability Requirements	**g**	
I01	**Laboratory**		DC \ Care Management
I02	**Imaging**		
I03	**Medications**		
I04	**Clinical Documentation**		
I05	**Chronic Disease Management/ Patient Documentation**		
I06	**Secondary Uses of Clinical Data**		
I07	**Administrative & Financial Data**		

MHSA - Behavioral Health Functional Functional Criteria MHSA Evaluation of EHRs

DMH EHR Functional Requirement Category Number	DMH EHR Functional Requirement Criteria Number	Specific Criteria	Discussion / Comments	EHR Road Map 1=Infrastructure 2=Practice Mgmt 3=Clinical Data 4=CPOE 5=Full EHR 6=Full EHR/PHR		Vendor Ratings Availability 2006	2007	2008	2009 and beyond
F-03	3.001	The system shall be able to display current multi-axial diagnoses associated with a client.	We assume current and active to mean the same thing.	3		H			
F-03	3.002	The system shall be able to maintain a history of all diagnoses associated with a client.	This means both current and inactive and/or resolved problems. These may be viewed on separate screens or the same screen. Ideally each discrete problem would be listed once.	3		H			
F-03	3.003	The system shall be able to maintain the onset date of the diagnoses.	It is a vendor design decision whether to require complete date or free text of approximate date.	3		H			
F-03	3.004	The system shall be able to record the chronicity (chronic, acute/self-limiting, etc.) of a diagnoses.		3		H			
F-03	3.005	The system shall be able to record the user ID and date of all updates to the diagnoses.		3		H			
F-03	3.006	The system shall be able to associate orders, medications, and notes with one or more diagnoses.	One shall be able to identify all visits for a particular diagnosis/problem. . Association can be made in structured data or in non-structured data.	3		H	H		
F-03	3.007	The system shall be able to associate orders, medications and notes with one or more diagnoses; association to be structured, codified data.		3					
F-03	3.008	The system shall be able to maintain a coded list of diagnoses.	For example: ICD-9 CM, ICD-10 CM, SNOMED-CT, DSM-IV. The Functionality WG will not specify which code set(s) are to be employed.	3		H			
F-03	3.009	The system shall be able to validate that the coded diagnosis is valid for the axis in which its entered.		3					

F-03	3.010	The system shall provide links to the diagnosis validation tables and shall be able to locally manage the table.	Provide categorization by Axis. To assist clinician in accurate documentation display diagnosis code and name upon diagnosis code entry to EHR system.	3					
F-03	3.011	The system shall be able to display inactive and/or resolved diagnoses.		3		X			
F-03	3.012	The system shall be able to separately display active diagnoses from inactive/resolved diagnoses.		3					
F-03	3.013	The system shall accepts either DSM IV or ICD-9 diagnoses as determined by the system administrator.		3					
F-03	3.014	The system shall support cross-walk tables to translate the diagnoses from one classification scheme to another.		3					
F-03	3.015	The system shall track multiple diagnoses based on user-defined criteria, such as admission diagnosis and discharge diagnosis.		3					
F-04	4.001	The system shall be able to create and maintain medication lists.	The medication list shall be "client-centric" and shall include medications prescribed by any provider.	3		H			
F-04	4.002	The system shall be able to expressly indicate that the medication list has been reviewed by both the provider and client; this shall be a structured field.		3					
F-04	4.003	The system shall be able to record prescribed medications information including the identity of the prescriber.		3		H			
F-04	4.004	The system shall be able to maintain medication ordering dates		3		H			
F-04	4.005	The system shall be able to record lab results, future lab types and lab work required for medication monitoring .	Copied to Manage Results: 14.019	3					
F-04	4.006	The system shall be able to maintain other dates associated with medications including start, modify, renewal and end dates as applicable.		3		H			
F-04	4.007	The system shall be able to display medication history for the client. Minimum requirements are: Type, frequency, effective start date and end date, and dosage.	For clarification, medication history includes all medications prescribed since the EMR was established.	3		H			

F-04	**4.008**	The system shall be able to capture medications entered by authorized users other than the prescriber.	It is important to have all current medications in the system for drug interaction checking. This in the future would include the incorporation of medication history obtained from external electronic interfaces, e.g., from insurers, PBMs, etc. "User" means medical and non-medical staff who are authorized by policy to enter prescriptions or other documentation.	**3**		H			
F-04	**4.010**	The system shall be able to store the following information about medications: start/stop dates, prescriber, date/time last taken, side effects.		**3**					
F-04	**4.011**	The system shall be able to enter non-prescription medications, including over the counter and complementary medications such as vitamins, herbs and supplements.	This is important for interaction checking, associating symptoms with supplements e.g. the L-trytophan related eosinophila-myalgia syndrome.	**3**		H			
F-04	**4.012**	The system shall be able to record the source of medication information by client report (non verify).		**3**					
F-04	**4.013**	The system shall be able to exclude a medication from the current medication list (e.g., marked inactive, erroneous, completed, discontinued) and document reason for such action and the clinical authority authorizing removal of the medication from the medication list.	Reason for removal or discontinuation shall be captured as a discrete data element or as free text. In future this shall be structured.	**3**		H			
F-04	**4.014**	The system shall store medication information in discrete data fields such as dose, route, sig, dispense amount, refills, associated diagnoses, etc.	Only approved abbreviations shall be included.	**3**		M	L	M	H
F-04	**4.015**	The system shall be able to print a current medication list.		**3**		H			
F-04	**4.016**	The system shall be able to display current medications only.	Excluding prior medications to make current medications easier to identify. Any given medication shall display only once in the list.	**3**		H			
F-04	**4.017**	The system shall include standard medication codes associated with each medication in the list.	It is anticipated that upcoming eRx regulation and the work of AHIC will define these in the near future. This requires publication by HITSP of an implementation guide by 3/07. This requirement will be postponed for a year after the publication of such a guide if one is not available by 3/07.	**3**		H	H		

F-04	4.018	The system shall be able to enter uncoded or free text medications when medications are not on the vendor-provided medication database or information is insufficient to completely identify the medication.	Medications that are not on the vendor provided medication database or not enough information is available to completely identify the medication. This could be either uncoded (Synthroid unknown dose) or free text (blue hypertension pill).	3			H		
F-04	4.020	The system shall be able to enter or further specify in a discrete field that the client takes no medications, date ranges and the reason.		3			H		
F-04	4.021	The system shall be able to enter the source of medication history.	For example, By client report.	3					
F-04	4.022	The system shall be able to record the date of changes made to a client's medication list and the identity of the user who made the changes.	This information may appear as an optional view rather than a required view on the main screen. Need to capture the identity of the user and the date of changes made. Changes are to be recorded at the level of the individual medication.	3			M	H	
F-04	4.023	The system shall support the entry and viewing, on a single screen,of information about medications prescribed by the county, those being taken but prescribed by another provider, drug allergies, and past adverse reactions to particular medications.		3					
F-04	4.024	The system shall make Information readily available about medications that have been tried and considered ineffective and medications that are no longer being taken due to other reasons.		3					
F-04	4.025	The system shall support Tickler Engine reminder rules that estimate and flag when a client's prescribed medication might be running out.		3					
F-04	4.026	The system shall support the review and maintenance of a locally defined formulary and will display drugs determined to be 'first-choice' as defined by the medical administrator.		3					
F-04	4.027	The system shall allow for alternate formularies defined by local site to address special regulatory and county requirements.		3					
F-04	4.028	The system shall include access to the national Drug Classification (NDC) database.		3					
F-04	4.029	The system shall store common prescriptions for quick entry, with each provider having his/her most commonly prescribed medications displayed.		3					
F-04	4.030	The system shall support multiple drug formularies and prescribing guidelines.		3					

F-04	4.031	The system shall be able to update the progress note with prescription information.		3					
F-04	4.032	The system shall allow the provider to document the effectiveness or ineffectiveness of a medication.		3					
F-04	4.033	The system shall store refill and repeat prescription information.		3					
F-04	4.034	The system shall store prescription data for retrieval by any of the following: Drug name, Drug code number (NDC), Amount prescribed, and Schedule.		3					
F-04	4.035	The system shall provide the following drug/prescription order information: drug contraindication, active problem interaction, and appropriate results obtained.		3					
F-04	4.037	The system shall prompt for the client's involvement in an indigent drug payment program, and shall provide a reminder when the application renewal is due.		3					
F-04	4.038	The system shall be able to electronically print prescriptions.	Separated into 2 reqs: 4.038 and 11.017	3					
F-05	5.001	The system shall be able to capture and store lists of medications and other agents to which the client has had an allergic or other adverse reaction. The list shall contain the ability to reference source who states the allergic reaction.	~~The user determines what defines an allergy or adverse reaction.~~	3		H			
F-05	5.002	The system shall be able to specify the type and severity of allergic or adverse reaction.	Allergy type shall be specified as a discrete data element and/or as a free text description. This shall be a modifiable field.	3			H		
F-05	5.003	The system shall be able to specify the type of allergic or adverse reaction in a discrete data field.	Data does not need to be codified.	3					
F-05	5.004	The system shall be able to deactivate an item from the allergy and adverse reaction list.	This could include removal, marking as erroneous, or marking as inactive. "Remove" in this context implies specifying that an allergy or allergen specification is no longer valid or active as opposed to deleting the information from the database entirely. The user ID, date & time will be recorded per Security requirements.	3		H			

F-05	**5.005**	The system shall be able to specify the reason for deactivating an allergy/allergen from the allergy list.	Reason for deactivating an allergy type shall be specified as a discrete data element or in non-structured data. This could include removal, marking as erroneous, or marking as inactive. "Remove" in this context implies specifying that an allergy or allergen specification is no longer valid or active as opposed to deleting the information from the database entirely.	**3**			L	M	H
F-05	**5.006**	The system shall be able to record the deactivation of items from the allergy list and clinical authority authorizing removal of the allergy from the allergy list.	Necessary for medico-legal purposes. This could include removal, marking as erroneous, or marking as inactive. "Remove" in this context implies specifying that an allergy or allergen specification is no longer valid or active as opposed to deleting the information from the database entirely.	**3**		M	H		
F-05	**5.007**	The system shall be able to record the identity of the user who added, modified, inactivated or removed items from the allergy list, including attributes of the changed items with associated date stamps.	Attributes include the name of the allergen, the date of the change, and the action (added, modified, inactivated or removed).	**3**					
F-05	**5.008**	The system shall be able to display information which has been inactivated or removed from the list as well as details of information that has been modified.	~~Could include changing the type of reaction for a particular allergy - 2009?~~	**3**		L	L	H	
F-05	**5.009**	The system shall explicitly document that the allergy list was reviewed. The user ID and date stamp shall be recorded when the allergies reviewed option is selected.	Medico-legal and regulatory compliance. This requires the user to explicitly select this option documenting that they have reviewed the allergies with the client. Ideally this would be a structured field.	**3**		H	H		
F-05	**5.010**	The system shall explicitly document, in a structured field, that the allergy list was reviewed. The user ID and date stamp shall be recorded when the allergies reviewed option is selected.	Medico-legal and regulatory compliance. (For audit trail).	**3**					
F-05	**5.011**	The system shall be able to explicitly indicate that a client has no known drug allergies.	Medico-legal and regulatory compliance. This is meant to be specific to drug allergies. Expected to be available by 2008.	**3**		H			

F-05	**5.012**	The system shall be able to explicitly indicate that a client has no known non drug allergies.	Expected to be available by 2008.	**3**					
F-05	**5.013**	The system shall be able to explicitly indicate in a discrete field that a client has no known drug allergies.	Expected to be available by 2008.	**3**					
F-05	**5.014**	The system shall be able to explicitly indicate in a discrete field that a client has no known non drug allergies.	Expected to be available by 2009.	**3**					
F-05	**5.015**	The system shall be able to check for potential interactions between a current medication and a newly entered allergy.		**3**		L	L	H	
F-05	**5.016**	The system shall interface with third party databases that support automated drug allergy checking to be performed during the medication prescribing process.		**3**					
F-06	**6.001**	The system shall be able to capture, store, display, and manage client history.	~~Client history shall be from external and/or internal sources, including client PHR.~~ Examples include past service/treatments, diagnoses, procedures, family history and social history and hospitalization.	**3**		H			
F-06	**6.002**	The system shall be able to capture structured data in the client history.	Structure Data versus free-text data is this criteria's intent. This function demonstrates the ability of a system to capture structured data but does not define the required elements of the client history that shall be structured. Discrete data elements allow for searching and/or reporting by the EHR, and for this criterion the data could be free text or codified. Future functions would define the required client history elements that shall be captured discretely as structured data, and where appropriate codified terminologies will be used.	**3**		M	H		
F-06	**6.003**	The system shall be able to update a client history by modifying, adding, removing, or inactivating items from the client history as appropriate.	Requirement not predicated on the capture of structured data.	**3**		H			
F-06	**6.004**	The system shall be able to capture client history as both a presence and absence of conditions, i.e., the specification of the absence of a personal or family history of a specific diagnosis, procedure or health risk behavior.	Requirement not predicated on the capture of structured data.	**3**		H	H		
F-06	**6.007**	The system shall maintain name, date time of all additions and edits to client history.	In the Security requirement. - S5 and S6.	**3**					

F-06	6.008	The system shall provide for the entry of the source of the history.		3					
F-06	6.009	The system shall have the ability to define and track episodes of care for clients based on state and local definitions of episodes.	This includes: 1) Care provided to an individual within a given service/treatment area, by a specific provider, during a given time period; 2) Separate episodes for outpatient service/treatments and inpatient facility during the same time period; 3) Multiple concurrent outpatient episodes.	3					
F-06	6.010	The system shall support efficient retention of, and subsequent access to, post discharge client contact data.	This may include clinical case management, complaint, or grievance follow up or client surveys.	3					
F-06	6.011	The system shall provide viewing by authorized individuals of all clinical information on the history of past diagnoses, service/treatment plans, service/treatments, and medications.	Clinical Reporting	3					
F-06	6.012	The system shall provide clinical history view screens configurable to accommodate the varying needs of clinicians, case managers and clients.	Clinical Reporting	3					
F-06	6.013	The system shall be able to capture the client's immunization history.	Moved from 8.053.	3					
F-07	7.001	The system shall be able to create and display a summary list for each client that includes, at a minimum, the active problem list, current medication list, medication allergies and adverse reactions	Health record summary is at the client level as opposed to at the level of an individual visit or episode of care. Clinical Reporting	3		H			
F-07	7.002	Patient Encounter Documentation: The system shall provide the ability to view summary information regarding the patient's conditions on one customizable screen and California requirements for CSI and DCR.		3					
F-07	7.003	Patient Summary Page Level 1:The system shall provide the ability to review basic information about the patient including all demographics and insurance information		3					
F-07	7.004	Patient Summary Page Level 2: The system shall provide the ability to review prior visit reasons, active medications, active lab results, next appointments, etc.		3					
F-07	7.005	Patient Summary Page Level 3: The system shall provide strong health maintenance alerts, prior vitals, patient messages, chronic diseases and other patient specific information.		3					
F-07	7.006	Patient Summary Page Level 4: The system shall provide the ability to customize the patient summary page based on the unique needs of the physician and/or the practice.		3					
F-07	7.007	Patient Summary Page Level 4: The system shall provide the ability to customize the patient summary page based on the unique needs of the physician and/or the practice.		3					

F-08	**8.001**	The system shall be able to create clinical documentation or notes (henceforth "documentation").		**3**		H			
F-08	**8.002**	The system shall be able to display clinical documentation.		**3**		H			
F-08	**8.003**	The system shall be able to save a note in progress prior to finalizing the note.		**3**		H			
F-08	**8.004**	The system shall be able to record the date and time stamp at the creation of a clinical document and any status change when the document is completed and finalize.		**3**					
F-08	**8.005**	The system shall be able to finalize a note, i.e., change the status of the note from in progress to complete so that any subsequent changes are recorded as such.	Medico-Legal. User rights are determined by role-based access defined in security. Only authorized users can complete, change or finalize a clinical note. The words, "sign," "signature," "cosign," and "cosignature" are intended here to convey actions, rather than referring to digital signature standards. It is recognized that an electronic signature is useful here. However, a widely accepted standard for electronic signatures does not exist. Thus, the criteria calls for documenting the actions of authenticated users at a minimum. In the future, when appropriate digital signature standards are available, certification criteria shall be introduced using such standards.	**3**		H			

F-08	**8.006**	The system shall be able to record the identity of the user finalizing each note and the date and time of finalization.	Medico-Legal. User rights are determined by role-based access defined in security. Only authorized users can complete, change or finalize a clinical note. The words, "sign," "signature," "cosign," and "cosignature" are intended here to convey actions, rather than referring to digital signature standards. It is recognized that an electronic signature is useful here. However, a widely accepted standard for electronic signatures does not exist. Thus, the criteria calls for documenting the actions of authenticated users at a minimum. In the future, when appropriate digital signature standards are available, certification criteria shall be introduced using such standards.	**3**		H			
F-08	**8.007**	The system shall be able to cosign a note and record the date and time of signature.	The words, "sign," "signature," "cosign," and "cosignature" are intended here to convey actions, rather than referring to digital signature standards. It is recognized that an electronic signature is useful here. However, a widely accepted standard for electronic signatures does not exist. Thus, the criteria calls for documenting the actions of authenticated users at a minimum. In the future, when appropriate digital signature standards are available, certification criteria shall be introduced using such standards. ASTM has developed "2003 Updated ASTM Standard Guide for Electronic Authentication of Health Care Information" to address some of these issues.	**3**			H		
F-08	**8.008**	The system shall be able to addend notes that have been finalized.		**3**		H			

F-08	8.009	The system shall be able to identify the full content of a modified note, both the original content and the content resulting after any changes, corrections, clarifications, addenda, etc. to a finalized note.	Please see Security requirements.	3					
F-08	8.010	The system shall be able to record and display the identity of the user who addended or corrected a note, as well as other attributes of the addenda or correction, such as the date and time of the change.		3		H			
F-08	8.011	The system shall be able to enter free text notes.		3		H			
F-08	8.012	The system shall be able to filter, search or order notes by the provider who finalized the note.		3		H			
F-08	8.013	The system shall be able to filter, search or order notes by associated diagnosis within a client record.	This is intended to be the coded diagnosis and not free text in the body of a note.	3			M	H	
F-08	8.014	The system shall be able to capture client vital signs, including blood pressure, Temperature, heart rate, respiratory rate, height, and weight, as discrete data and the physical pain level.	It is understood that vendors shall support conversion to numeric values that can be graphed. Coding in ICD-9 CM, ICD-10 CM, SNOMED, UMLS, etc., would enhance interoperability and for public health surveillance or clinical research.	3		H			
F-08	8.015	The system shall be able to graph height and weight over time.	Moved up from CA-F92, F93, F94	3					
F-08	8.016	The system shall be able to calculate and graph body mass index (BMI) over time.		3					
F-08	8.017	The system shall be able to compare body mass index (BMI) to standard norms for age and sex over time.		3					
F-08	8.018	The system shall be capable of indicating to the user when a vital sign measurement falls outside a preset normal range. Authorized users shall set the normal ranges.		3					
F-08	8.019	The system shall be able to associate standard codes with discrete data elements in a note.	We need to add this to the glossary. Examples include but are not limited to SNOMED-CT, ICD-9 CM, ICD-10 CM, DSM-IV, CPT-4, MEDCIN, and LOINC. This would allow symptoms to be associated with SNOMED terms, labs with LOINC codes, etc. The code associated with a note would remain static even if the code is updated in the future.	3		H	L	M	H

F-08	**8.020**	The system shall provide templates for inputting data in a structured format as part of clinical documentation. This shall include structured progress notes and intake assessments such as the mini mental health exam.	Codified data are data that is structured AND codified according to some 'external' industry accepted standard such as ICD-9 CM, ICD-10 CM, SNOMED-CT, and CPT-4.	**3**		H			
F-08	**8.021**	The system shall be able to customize clinical templates.	Customizations shall be site specific.	**3**		H			
F-08	**8.022**	The system shall provide templates for displaying summary data in a structured format.	Examples might include the CDR or the CDA. This requirement does not specify a particular format although many vendors will choose to use the harmonized CCR/CDA/CRS once available.	**3**		H	M	H	
F-08	**8.023**	The system shall be capable of recording comments by the client or the client's representative regarding the accuracy or veracity of information in the client record (henceforth 'client annotations'). This includes external documentation incorporated in the client records.	For 2007 it is sufficient for these to be recorded as either free-text notes (see item F59) or scanned paper documents (see item F86). It is not required that the system facilitate direct entry into the system by the client or client's representative.	**3**					
F-08	**8.024**	The system shall display client annotations in a manner which distinguishes them from other content in the system.	Examples include but are not limited to use of a different font or text color, a text label on the screen indicating that the comments are from a client or client's representative, etc. "Distinguishable" refers specifically to comments made by the client or client's representative, but does not refer to the individual components of that chart that they may disagree with.	**3**					
F-08	**8.025**	The system shall be able to identify and maintain client or client proxy completed clinical information.	Once verified by a physician and shared with other parts of the chart, the shared data does not need to be identified as client completed in all sections where data may be shared, but the original client completed information shall be maintained.	**3**			M	H	

F-08	8.026	The system shall be able to prevent billing/claiming until related notes are finalized.	Copied to 42.196: Administrative A/R. Kept here to review again to see if there is a requirement relative to managing clinical data such as reminding the users to finalize their notes.	3					
F-08	8.027	The system shall be able to document group therapy per California DMH guidelines.	review again	3					
F-08	8.028	The system shall provide a core summary for group therapy notes that can be included in the records of all group participants, with the ability to add client-specific information to a participant's record.		3					
F-08	8.029	They system shall be able to capture documentation and travel time.	review again	3					
F-08	8.030	The system shall allow clinical documentation utilizing a combination of system defaults, provider defined and customized templates.		3					
F-08	8.031	The system shall support automatic service/treatment transactions linked to a progress note entered and signed by a clinician.		3					
F-08	8.032	The system shall support progress notes "pended" by a clinician or by a clinical reviewer to be held and not forwarded to the billing system. This automatic generation feature support "switched" on or off by the system administrator. The system administrator shall be able to enable or disable feature for particular organizational providers or particular clinical staff.		3					
F-08	8.033	The system shall document clinical episodic data per state and local guidelines		3					
F-08	8.034	The system shall document client care assessments per state and local guidelines		3					
F-08	8.035	The system shall offer various standard intake assessment instruments including optional 3rd party licensed assessment tools.		3					
F-08	8.036	The system shall supports the creation of user defined intake assessment forms.		3					
F-08	8.037	The system shall capture progress notes for individuals as well as groups.		3					
F-08	8.038	The system shall provide free form clinical note text entry using standard word processing functions which include spell checking.		3					
F-08	8.039	The system shall ensure notes are easily accessible as part of an integration with the service/treatment entry process.		3					

F-08	8.040	The system shall have the option to generate service/treatment transactions as part of the progress note entry.		3					
F-08	8.041	The system shall allow that while writing a progress note, clinicians have ready access to the current authorization information as well as the service/treatment plan.		3					
F-08	8.042	The system shall provide that each progress note can be linked with key elements of the service/treatment plan as required by regulatory guidelines.		3					
F-08	8.043	The system shall allow administrators to integrate with clinical documents and notes program specific fields for local data requirements.		3					
F-08	8.044	The system shall provide a location check log that supports the tracking of patients by location on a user-defined basis (e.g. every 5 or 10 minutes). This component is used primarily at inpatient facilities.		3					
F-08	8.045	The system shall support electronic signatures of clinical documentation.		3					
F-08	8.046	The system shall support a process whereby a clinical document can be saved but not completed, and completed, signed and finalized. Finalized clinical documents can be appended under separate signature. All steps in the clinical documentation process are date and time stamped. Signed documentation shall not be modified, in keeping with medical record standards. The system is flexible enough to support emerging electronic signature technologies.		3					
F-08	8.047	The system shall be able to merge client health record data if a client has more than one identical type data record opened erroneously.	Does not have to be only duplicate data found in both records.	3					
F-08	8.048	The system shall be able to display and review all data in two similar type client health record records for the same client, highlighting the data that is different.	This will support determining the correct client health record information that should exist subsequent to merging two records to one.	3					
F-08	8.049	The system shall require user confirmation prior to merging any client health record information.		3					
F-08	8.050	If two client health record records are erroneously merged, the system shall provide a mechanism for recreating them as separate records.		3					
F-08	8.051	The system shall be able to define and display specialized questions based on: Client's gender, age and presenting problem.		3					
F-08	8.052	The system shall be able to capture and store risk factors for all new clients.		3					

F-08	8.054	The system shall be able to collect and store the client's family medical history.		3					
F-08	8.055	The system shall require that the progress note be electronically signed upon its completion.	Electronic Signature	3					
F-08	8.056	The system shall trigger a reminder to staff for all progress notes that have not been signed.		3					
F-08	8.057	The system shall include a progress note and mental status evaluation template that is problem oriented and can, at the user's option, be linked to a problem on the service/treatment plan.		3					
F-08	8.058	The system shall support clinical access to a medical terminology dictionary.		3					
F-08	8.059	The system shall be able to create a heading for progress notes which include: Client identification number, client name, date of service/treatment, time of day service/treatment was rendered, duration of service/treatment, type of service/treatment, and provider identifier.		3					
F-08	8.060	The system shall provide client service/treatment payor billing based on clinical service/treatment note entry.	This approach is in contrast to billing caused by client service/treatment data entry procedures which are performed separate from clinical service/treatment note entry. Copied to Administrative A/R: 42.197 as well	3					
F-08	8.061	The system shall provide service/treatment templates that integrate to clinical documentation for client service/treatments.	Templates assist clinical staff in correct service/treatment entry.	3					
F-08	8.062	The system shall allow the ability to enter group progress notes .	Moved from Capture External Clinical Documents: 9.012.	3					
F-08	8.063	The system shall not require the user to enter group progress notes for every client. Clinical documentation relevant to all group attendees shall only be entered once. The system shall allow display of a specific client's progress notes.	Moved from 9.013.	3					
F-08	8.064	Dictation: The system shall provide base line dictation where the physician can dictate a report, electronically send the report to the transcriber and, after completion, the report can be imported back into the patient's EHR folder.		3					
F-08	8.065	Dictation: The system shall provide advanced dictation where data is automatically captured from within the EHR and the physician's only needs to dictate specific findings within a specific section of the patient's note. The transcriber receives an electronic wave file, and after transcription, the typed data is automatically imported back into the section of the note.		3					

F-08	8.066	Dictation: The system shall provide advanced dictation with the capability of voice-to-text dictation designed to eliminate 90% of all transcription costs.		3					
F-08	8.067	Dictation: The system shall provide advanced, nationally recognized, practice customized voice to text dictation based on practice specific requirements and clinical guidelines based on the patient's clinical condition.		3					
F-08	8.068	Dictation: The system shall provide advanced, nationally recognized, practice customized voice to text dictation based on practice specific requirements and clinical guidelines based on the patient's clinical condition.		3					
F-08	8.069	Behavioral Information: The system shall provide full, interactive, mental/behavioral health templates.		3					
F-08	8.070	Behavioral Information: The system shall provide nationally recognized mental/behavioral health care plans and alerts designed to improve the capture of patient related information based on best practices.		3					
F-08	8.071	Behavioral and Medical Information: The system shall provide the ability to share clinical information gathered during a medical visit including: clinical alerts, active medications, lab results, diagnostic codes, allergies, a history of the present illness, and a review of the client's symptoms.		3					
F-08	8.072	Behavioral and Medical Information: The system shall provide functionality for both mental/behavioral health and medical conditions all within one database following organization-specific security rules based on best practices.		3					
F-08	8.073	Behavioral and Medical Information: The system shall provide functionality for both mental/behavioral health and medical conditions all within one database following organization-specific security rules based on best practices.		3					
F-09	9.001	The system shall be able to capture and store external documents.	Scanned documents are sufficient in 2005, granular data will be expected in the future. This covers all types of documents received by the practice that would typically be incorporated into a health record, including but not limited to faxes, referral authorizations, consultant reports, and client correspondence of a clinical nature.	3		H			
F-09	9.003	The system shall be able to save scanned documents as images.		3		H			
F-09	9.004	The system shall be able to receive, store in the client's record, and display text-based external reports.	This could be either from an external system or from scanning with optical character recognition. Integration here means the ability to find and display the documents within the system.	3		H			

F-09	9.005	The system shall be able to index and retrieve scanned documents based on such indexes as the document type, the date of the original document, the date of scanning, subject and title.		3					
F-09	9.006	The system shall provide access to clinical images. They shall be accessible from within the client's chart and labeled and date-time stamped or included in a client service/treatment document. These images shall be stored within the system or be provided through direct linkage to external sources.	These images may include but are not limited to radiographic, digital or graphical images. Eventually the goal would be to allow linkage to external systems such as a hospital PAC system.	3			L	M	H
F-09	9.008	The system shall be able to accept, store in the client's record, and display medication details from an external source.	External source may include a retail pharmacy, the client, or another provider. Medication details include strength and sig. Does not imply that this date will populate the medication module; that functionality will be required in future. Year to be determined based on applicability of available standards.	3		L	L	H	
F-09	9.009	The system shall be able to accept, store in the client's record, and display structured text-based reports received from an external source.	This allows for more granular integration of data.	3		M	H		
F-09	9.010	The system shall be able to accept, store in the client's record, and display, codified data received from an external source.	Such as those sent from another physician using a standardized format. Coding schema will be determined by HITSP and will be included in test scenarios in appropriate years.	3		L	L	H	
F-09	9.011	The system shall provide ability to store the source of documents from an external source.		3					
F-09	9.012	Document Image Management: The system shall provide the ability to scan in new documents at the front and back desk with workflow guidelines for routing documents for signature or review.		3					
F-09	9.013	Document Image Management: The system shall provide nationally recognized, practice customized document imaging that is designed to capture both clinical and financial data regarding the patient, which can be used by both the clinical staff and the financial/billing staff.		3					
F-09	9.014	Document Image Management: The system shall provide the ability to create specific files for scanning of staff information, invoices, and other documents specific to the practice, but not oriented towards a given patient.		3					
F-09	9.015	Document Image Management: The system shall provide the ability to create specific files for scanning of staff information, invoices, and other documents specific to the practice, but not oriented towards a given patient.		3					

F-10	**10.001**	The system shall provide access to client instructions and client educational materials, which shall reside within the system or be provided through links to external sources.	An example would be a vaccine information statement.	**3**		H	H		
F-10	**10.002**	The system shall provide access to medication instructions, which shall reside within the system or be provided through links to external sources.		**3**		H			
F-10	**10.003**	The system shall provide access to test and procedure instructions that can be customized by the physician or health organization. These instructions shall reside within the system or be provided through links to external sources.	This item relates to customization of instructions, not to recording in client record that instructions have been provided.	**3**		M	H		
F-10	**10.004**	The system shall be able to record that client specific instructions or educational material were provided to the client.	This does not require automatic documentation.	**3**		H			
F-10	**10.005**	The system shall be able to create client specific instructions.		**3**		H			
F-10	**10.006**	The system shall have the capacity to create, import, review, update, or delete client education materials.		**3**					
F-10	**10.007**	The system shall provide printed client education materials in culturally appropriate languages on demand or automatically at the end of the encounter.		**3**					
F-10	**10.008**	The system shall include the ability to develop client instructions for a broad range of service/treatments delivered by providers.		**3**					
F-10	**10.009**	The system shall allow user modification to instructions to suit individual client needs without altering the original content.		**3**					
F-10	**10.010**	The system shall enable the linkage of client instructions to care plans/practice guidelines/orders/ enabling automatic printing.		**3**					
F-10	**10.011**	The system shall allow client instructions to be printed on demand independent of care plans/guidelines/orders.		**3**					
F-10	**10.012**	The system shall support the development of a user-defined online Crisis Management Plan that is generally prepared by the client and their case manager. If a client goes into crisis this plan is easily accessible to provide guidance to staff on the care team and other providers who have contact with the client.		**3**					
F-10	**10.013**	The system shall support efficient client advance directives development, and maintenance.		**3**					

F-10	10.014	The system shall support integration of client advance directives with other system functions. This includes linkages to standard care plans, guidelines, protocols; clinical task assignment and routing; Inter-provider communication; Scheduling; Manage Practitioner/Patient relationships; and Enforcement of Confidentiality.	Examples are: 1) Referrals of client to other provider care would include sharing of advance directives, as appropriate. 2) Medication prescription systems may be limited by advance directives.	3					
F-10	10.015	The system shall support user-defined screens for tracking crisis episode data including date and time of first contact, referral source, clinical notes about the crisis including user-defined checklists and text-based crisis notes that allow for the recording of diagnosis, level of functioning and other relevant clinical data.		3					
F-10	10.016	The system shall support tracking and easy viewing of the service/treatments provided during the crisis episode.		3					
F-10	10.017	Patient Education: The system shall provide educational materials from national companies, which is updated regularly and that can be modified by the practice and printed in multiple languages.		3					
F-10	10.018	Patient Education: Rather than offering a specific patient access to an established (general) source or platform, the system shall couple the diagnosis, treatment decision or condition of the patient with the dedicated specific education information that applies to the actual case.		3					
F-10	10.019	Patient Education: Rather than offering a specific patient access to an established (general) source or platform, the system shall couple the diagnosis, treatment decision or condition of the patient with the dedicated specific education information that applies to the actual case.		3					
F-14	14.001	The system shall be able to indicate normal and abnormal results based on data provided from the original data source.	As each lab has it's own normal values, these shall be reflected in the indication as to whether a lab is normal or abnormal.	3		H			
F-14	14.002	The system shall be able to display numerical results in flow sheets and graphical form in order to compare results, and shall be able to display values graphed over time.	It is desirable for the system indicate if abnormal results are high or low.	3		M	H		
F-14	14.003	The system shall be able to display non-numeric current and historical test results as textual data.		3		H			
F-14	14.005	The system shall be able to filter or sort results by type of test and test date.		3					
F-14	14.006	The system shall be able to filter or sort results by client in areas where results from multiple clients are displayed.		3					
F-14	14.007	The system shall be able to forward a result to other users.		3		M	M	H	

F-14	**14.008**	The system shall be able to link the results to the original order.	In 2007 this link can be effected manually by changing the status of the order from pending to complete. Future requirements could automate this link for certain electronically received labs although the requirement shall not require that all types of orders be electronically linked to the results since the variety of result formats can be quite large (PT consult, Diabetes education...) and even the variety of lab result formats can be wide.	**3**		M	M	H	
F-14	**14.009**	The system shall allow free text comment to a result that can be seen by another user who might subsequently view that result.		**3**		H	H		
F-14	**14.010**	The system shall be able to associate one or more images with a result.	Through direct storage or links to the data.	**3**		M	M	H	
F-14	**14.014**	The system shall provide the ability to enter results directly into the system.		**3**					
F-14	**14.015**	The system shall provide an intuitive, user-customizable result entry screen linked to orders.		**3**					
F-14	**14.016**	The system shall allow authorized users to copy selected results into a note.		**3**					
F-14	**14.017**	The system shall display the following result data: Client name, date/time of order, date/time results were last updated, test or order name, alerts identifying changes/amendments to the test or procedure.		**3**					
F-14	**14.018**	The system will use visual cues to highlight abnormal results.		**3**					
F-14	**14.019**	The system shall be able to record lab results, future lab types and lab work required for medication monitoring .	Copied from Manage Medication List: 4.005	**3**					
F-16	**16.001**	The system shall have the ability to provide access to standard care plan, protocol and guideline documents when requested at the time of the clinical service/treatment. These documents may reside within the system or be provided through links to external sources.	This requirement could be met by simply including links or access to a text document. Road map would require more comprehensive decision support in the future. This includes the use of clinical trial protocols to ensure compliance.	**3**		H			

F-16	16.002	The system shall be able to create site-specific care plan, protocol, and guideline documents.	This includes the use of clinical trial protocols to ensure compliance. It is expected that in the future discrete data elements from other areas of the chart will populate matching fields.	3		H			
F-16	16.003	The system shall be able to modify site-specific standard care plan, protocol, and guideline documents obtained from internal and external sources.		3		M	H		
F-16	16.004	The system shall trigger an alert for upcoming care plan due dates.		3					
F-16	16.005	The system shall provide a variety of pre-defined assessment forms .	Examples include psycho-social assessments, intake assessments, Addiction Severity Index (ASI), inpatient evaluations, and residential placement evaluations.	3					
F-16	16.006	The system shall provide a forms development tool set designed to allow locally defined assessment forms to be created. Locally defined forms can capture data as defined by the system administrator.	Such forms may also display data collected from “non-clinical” functions (e.g. demographic data, address, current diagnosis).	3					
F-16	16.007	The system shall include an assessment function configurable to generate targeted problems for service/treatment and such problems can flow to the service/treatment planning process.		3					
F-16	16.008	The system shall allow clinicians to build service/treatment plans for various target populations.		3					
F-16	16.009	The system shall support user-configurable data sets which describe key components of service/treatment plans appropriate to specific target populations.		3					
F-16	16.010	The system shall provide immediate clinician access to industry standard clinical libraries of clinical evidence-based practice guidelines.	Access to be available for inquiry during the clinical decision making process including progress notes, service/treatment planning and prescribing. Intended to support clinical diagnosis, problem, goals, objectives and interventions definitions.	3					
F-16	16.011	The system shall allow users to configure views of clinical evidence-based practice guidelines libraries.	These libraries will be definable by user, program and site.	3					
F-16	16.012	The system shall support practice guidelines customizable to respond to various theoretical approaches.		3					
F-16	16.013	The system shall make available current and past clinical authorizations as well as clinical outcome results.		3					

F-16	16.014	The system shall allow definition and/or modification by authorized clinical supervisors of all clinical guideline elements that underlie service/treatment planning .		3					
F-16	16.015	The system shall make printable versions of service/treatment plans available for clients.		3					
F-16	16.016	The system shall supports the process of obtaining client signatures on service/treatment plans.		3					
F-16	16.017	The system shall support the development of client created wellness action plans. Clients may designate users authorized to view such plans. A printable version of the plan is available for clients.	Such plans contain information provided by the client which includes their personal strategy for recovery. The plan may also include crisis contact information, advance medication directions, and advance directives from the consumer.	3					
F-16	16.018	The system shall be able to import/create, review and amend information about the provider's explanation and the client understanding of the recommended and/or alternative care plan, the actions taken to safeguard the client to avert the occurrence of morbidity, trauma, infection, or condition deterioration.		3					
F-16	16.019	The system shall be able to identify and keep key elements of data for each service/treatment episode. Due to multiple locations of service/treatments, it shall be helpful to know at any point in time, which types of service/treatments have been received or are currently being received. Key client –related service/treatment information is obtained at each presentation of a new level of service/treatment.		3					
F-16	16.020	The system shall import information from prior service/treatment plans to minimize date entry, but shall maintain both original and new information as separate service/treatment plans.		3					
F-16	16.021	The system shall have a module for capturing all five axes of DSM-IVR, using problem lists for adults and children for Axis IV and GAF/CGAS scores for Axis V.		3					
F-16	16.022	The system shall provide an easy method of presenting problem lists (i.e., pull down lists), with the ability to add additional issues.		3					
F-16	16.023	The system shall have service/treatment intervention suggestions which are tied to issues selected best practice intervention.		3					
F-16	16.024	Assessment and Treatment Plans: The system shall provide Assessment and Treatment plans based on national best practice guidelines		3					

F-16	**16.025**	Assessment and Treatment Plans: The system shall provide Assessment and Treatment plans based on national best practice guidelines		**3**					
F-17	**17.001**	The system shall be able to record the reason for variation from care plans, guidelines, and protocols as discrete data.		**3**		H	H		
F-19	**19.001**	The system shall document medication administration.		**3**		H			
F-19	**19.002**	The system shall document, for any medication, the medication type, dose, time of administration, route, site, lot number, expiration date, manufacturer, and user ID as structured documentation.		**3**					
F-21	**21.001**	The system shall be able to establish criteria for disease management, wellness, and preventive service/treatments based on client demographic data (minimally age and gender).	This includes the use of clinical trial protocols to ensure compliance.	**3**		H			
F-21	**21.002**	The system shall display triggered alerts based on established guidelines.	Guidelines may be from national organizations, payers, or internal protocols. It is expected that in the future discrete data elements from other areas of the chart will populate matching fields. It is assumed that when a service/treatment is completed, this change will be immediately reflected with removal of the prompt.	**3**		H			
F-21	**21.003**	The system shall be able to establish criteria for disease management, wellness, and preventive service/treatments based on clinical data (problem list, current medications).	Lab results in future years	**3**		M	H		
F-21	**21.004**	The system shall be able to update disease management guidelines and associated reference material.	This allows the system's decision support tools to support changes in best practice guidelines.	**3**		H			
F-21	**21.005**	The system shall be able to update preventive service/treatments/wellness guidelines and associated reference material.		**3**		H			
F-21	**21.006**	The system shall be able to override guidelines.		**3**		H			
F-21	**21.007**	The system shall be able to document reasons disease management or preventive service/treatments/wellness prompts were overridden.	Needed for medico-legal reasons and clinical decision support.	**3**		M	H		

F-21	**21.008**	The system shall be able to modify the rules or parameters upon which guideline-related alert triggers are based.	This is necessary for modifications as guidelines change or practices wish to adhere to more stringent levels for example, using a HbA1c target of 6.5% instead of 7%.	**3**		L	M	H	
F-21	**21.009**	The system shall trigger clinical "Red Flag" alerts that present urgent clinical information such as danger warnings, suicide watch or similar, drug allergies, history of adverse reactions to specific drugs, and other urgent precautions.		**3**					
F-21	**21.010**	The system shall trigger "Red Flag" alerts to be viewed at various key screens including those that handle progress notes, appointments and service/treatment plans.		**3**					
F-21	**21.011**	The system shall assure triggered "Red Flag" alerts are visible to all authorized users.		**3**					
F-21	**21.012**	The system shall support disease management registered by: Allowing patient tracking and follow up based on user defined diagnoses; integrating all patient information within the system; providing a longitudinal view of the patient medical history; providing access to patient service/treatments and outcomes.		**3**					
F-21	**21.013**	The system shall automatically identify all high-risk patients and notifies clinical staff for preventive care.		**3**					
F-21	**21.014**	The system shall utilize user-authored and/or third party developed clinical guidelines for disease and registry management.		**3**					
F-21	**21.015**	The system shall generate follow-up letters to physicians, consultants, external sources, and clients based on a variety of parameters such as date, time since last event, etc., for the purpose of collecting health data and functional status for the purpose of updating the client's record.		**3**					
F-21	**21.016**	The system shall provide the capability to link all other Disease Management functions to all other sections of the EHR.		**3**					
F-21	**21.018**	Disease Management and Clinical Trials: The system shall provide base line Disease Management and Outcomes Reporting with Clinical Trials reporting.		**3**					
F-21	**21.019**	Disease Management: The system shall provide Disease Management that can be customized by the practice.		**3**					
F-21	**21.020**	Disease Management: The system shall provide nationally recognized, practice customized disease management tracking based on a patient's disease state or condition.		**3**					

F-21	**21.021**	Disease Management: The system shall prompt the user with lists of relevant tests and therapies as well as other relevant symptoms, history questions and physical finding questions that might not have been asked yet.		**3**					
F-21	**21.022**	Disease Management: The system shall prompt the user with lists of relevant tests and therapies as well as other relevant symptoms, history questions and physical finding questions that might not have been asked yet.		**3**					
F-22	**22.001**	The system shall be able to identify preventive service/treatments, tests, or counseling that are due on an individual client.	In the future, the system shall perform this automatically and proactively "contact" client(s) without physician intervention (e.g. automated reminder letter). These guidelines might come from national organizations, medical societies, etc.	**3**		M	H		
F-22	**22.002**	The system shall be able to identify criteria for disease management, preventive, and wellness service/treatments based on clinical data (problem list, current medications, lab values).		**3**		L	L	H	
F-22	**22.003**	The system shall be able to modify guidelines that trigger reminders.		**3**		M	H		
F-22	**22.004**	The system shall be able to notify the provider that clients are due or are overdue for disease management, preventive, or wellness service/treatments.		**3**		M	H		
F-22	**22.005**	The system shall be able to produce a list of clients who are due or are overdue for disease management, preventive, or wellness service/treatments.		**3**		M	H		
F-22	**22.006**	The system shall be able to automatically generate letters to remind the client or the client's guardian of service/treatments that are due.	Reminders that include PHI shall be delivered through HIPAA-compliant means.	**3**		L	L	H	
F-22	**22.007**	The system shall be able to automatically generate an electronic reminder to the client or the client's guardian of service/treatments that are due.	Reminders that include PHI shall be delivered through HIPAA-compliant means.	**3**					
F-22	**22.008**	Disease Management and Clinical Trials: The system shall provide advanced Disease Management and Outcomes Reporting with Clinical Trials reporting that is useable for multiple diseases and problems, provides reminders for health maintenance, prompts visits and screenings protocols, has prompts/alerts that can be modified by clinician, tracks patient visits, tracks patient lab results, flags unfilled orders for labs, prescriptions, etc.		**3**					
F-23	**23.001**	The system shall be able to create and assign tasks by user or user role.	Examples of tasks are messages, notifications, inbox items, worklist to-do's. This task assignment refers to internal users. External tasks would be handled under ordering section.	**3**		H			

F-23	23.002	The system shall be able to present a list of tasks by user or user role.	Examples of tasks are messages, notifications, inbox items, worklist to-do's. This task assignment refers to internal users. External tasks would be handled under ordering section.	3		H	M	H	
F-23	23.003	The system shall be able to re-assign and route tasks from one user to another user.		3		M	M	H	
F-23	23.004	The system shall be able to designate a task as completed.		3		H			
F-23	23.005	The system shall be able to remove a task without completing the task.	Removing a task eliminates it from an individual user's "to do" list, not from audit logs, etc.	3		H			
F-23	23.006	The system shall be able to automatically escalate incomplete tasks to the appropriate supervisor or authority.	Escalation can be based on elapsed time or time of day.	3		L	L	H	
F-24	24.002	The system shall be able to incorporate paper documents from external providers into the client record.		3		H			
F-24	24.006	The system shall be compatible with multiple payment methods for services provided under an authorization including fee for service, case rate, per diem, etc.		3					
F-24	24.007	The system shall support several methods of setting, tracking and providing reminders of service/treatment limits for each type of authorization.	Methods include number of visits or days, number of client or clinician service/treatment hours, number of days or weeks, specific service/treatment codes, service/treatment codes clusters, or specific dollar limits.	3					
F-24	24.008	The system shall be integrated with options for linking specific authorization types to insurance plans to aid in the utilization management of those authorizations. As service/treatment is provided, actual service/treatments shall be comparable with authorized amounts.		3					
F-24	24.009	The system shall have multiple ways of notifying providers and utilization managers of remaining balances and impending authorization expirations, including during data entry, regular reports and tickler systems.		3					
F-24	24.010	The system shall integrate with an authorization system with user-defined rules for determining whether provider payment for unauthorized service/treatments will be pended or paid and whether these service/treatments will be billed to a third party payor.		3					

F-24	24.011	The system shall support electronically processed Notice of Action letters to a provider and client, informing them of service/treatment denial/reduction and informing them of their due process rights.	NOA example: Authorizations are denied because medical necessity has not been met, or if a level of care request is reduced,	3					
F-24	24.012	The system shall have the ability to record and track communications with provider organizations and individual clinicians.	Includes the recording and tracking of notes related to provider requests and complaints as well as contacts initiated by county staff.	3					
F-24	24.013	The system shall include a tickler system for ensuring follow up of outstanding inter-provider communications.		3					
F-24	24.014	The system shall support processes that automatically support referral of potential Medi-Cal indigents to Medi-Cal eligibility determination staff.	Examples include referral letters or direct scheduling with county social services Medi-Cal eligibility workers or Social Security Department workers.	3					
F-24	24.018	Clinician Dashboard: The system shall provide a base line clinician dashboard that shows patients for the day and any messages that are out standing, including patient calls, refill requests, lab orders to review, etc.		3					
F-24	24.019	Clinician Dashboard: The system shall provide a clinician dashboard that can receive and route clinical messages and reports to anyone within the practice.		3					
F-24	24.020	Clinician Dashboard: The system shall provide a clinician dashboard that can track the location of the patient throughout the clinic.		3					
F-24	24.021	Clinician Dashboard: The system shall provide a clinician dashboard that can transmit clinical messages and reports to clinicians outside of the office.		3					
F-24	24.022	Clinician Dashboard: The system shall provide a clinician dashboard that includes practice statistics regarding visits, revenues, and AR days by day, month, and year.		3					
F-24	24.023	Clinician Dashboard: The system shall provide a clinician dashboard that includes practice statistics regarding visits, revenues, and AR days by day, month, and year.		3					
F-24	24.024	Clinical Messages: The system shall provide basic e-messages from and to staff to help eliminate “sticky notes”.		3					
F-24	24.025	Clinical Messages: The system shall provide e-messages from staff including automated routing and tracking of messages.		3					
F-29	29.001	The system shall be able to define one or more reports as the formal health record for disclosure purposes.	This allows the practice to not print demographics, certain confidential sections, or other items. Report format may be plain text initially. In the future there will be a need for structured reports as interoperability standards evolve.	3		M	H		

F-29	**29.002**	The system shall be able to generate hardcopy or electronic output of part or all of the individual client's health record.	This could include but is not limited to the ability to generate standardized reports needed for work, school, or athletic participation.	**3**		H			
F-29	**29.003**	The system shall be able to generate hardcopy and electronic output by date and/or date range.		**3**		M	H		
F-29	**29.004**	The system shall be able to export structured data which removes those identifiers listed in the HIPAA definition of a limited dataset. This export on hardcopy and electronic output leaves the actual PHI data unmodified in the original record.	De-identifying data on hardcopy or electronic output is necessary for research. However, it is emphasized that this function is not intended to cleanse the text in the note or data in the original record. As per HIPAA Standards for Privacy of Individually Identifiable Health Information, 45 CFR Parts 160 and 164, identifiers that shall be removed are: 1. Names; 2. Postal address information, other than town or city, state and zip code; 3. Telephone numbers; 4. Fax numbers; 5. Electronic mail addresses; 6. Social security numbers; 7. Health record numbers; 8. Health plan beneficiary numbers; 9. Account numbers; 10. Certificate/license numbers; 11. Vehicle identifiers and serial numbers, including license plate numbers; 12. Device identifiers and serial numbers;	**3**		L	M	H	H
F-29	**29.005**	The system shall be able to create hardcopy and electronic report summary information (procedures, medications, labs, allergies, and vital signs).	The report that's produced shall be organized by section to make it easier to read.	**3**		M	M	H	
F-29	**29.006**	The system shall have the ability to provide support for disclosure management in compliance with HIPAA and applicable law.	This criterion may be satisfied by providing the ability to create a note in the client's record. More advanced functionality may be market differentiators or requirements in later years.	**3**					

F-29	29.007	The system shall be able to access, or extract, separate health record components to display, report , print, or transfer a complete logical health record when necessary.	This requirement includes health components distributed among different software applications	3					
F-29	29.008	The system shall be able to extract partial or complete health record information for clinical, administrative, financial, research, quality analysis, and public health purposes.	Includes ability to output partial or complete history of client healthcare.	3					
F-30	30.001	The system shall be able to document a client service/treatment.		3		H			
F-30	30.002	The system shall be able to document service/treatments by one or more of the following means: direct keyboard entry of text; structured data entry utilizing templates, forms, pick lists or macro substitution; dictation with subsequent transcription of voice to text, either manually or via voice recognition system.	This does not preclude entry via new technologies.	3		H			
F-30	30.003	The system shall be able to associate individual service/treatments with diagnoses.		3					
F-30	30.004	The system shall have the ability to provide filtered displays of service/treatments based on service/treatment characteristics, including date of service, service/treatment provider and associated diagnosis.		3		H	M	H	
F-30	30.005	The system shall allow service/treatment data entry that accurately supports California billing requirements,	Includes collection of minutes of service/treatment, co-therapist information, and number in group for outpatient service/treatments.	3					
F-30	30.006	The system shall support a variety of data entry methods that are typically performed by non-clinical support staff.	This includes single service/treatment entry screen, usually connected with outpatient and case management service/treatments; multi-client and/or multi-service/treatment log entry; and service/treatment entry for 24-hour programs that allows for the rapid service/treatment recording of a daily census.	3					
F-30	30.007	The system shall have data entry methods designed to allow maximum efficiency for outpatient, day treatment, and 24-hour programs.		3					
F-30	30.009	The system shall provide efficient functionality that allows providers to enter their own service/treatment data.		3					

F-30	30.010	The system shall record the date-time stamp at any creation, void or replacement of a service/treatment record .	Security	3					
F-30	30.011	The system shall record the user who entered, voided or replaced a service/treatment record.	Security	3					
F-30	30.012	The system shall provide efficient support for admission, discharge and recording of service/treatments for a crisis service/treatment.		3					
F-30	30.013	The system shall provide a data entry screen to support the admission, discharge and recording of service/treatments for a crisis service/treatment.	See workflow # 23 for related workflow support across system functions.	3					
F-30	30.014	The system shall immediately perform essential validations as service/treatments are entered in to the system.	Examples of essential validations are: 1)Appropriate provider credentials; 2) service/treatment time start / end or duration is acceptable; 3) Location of service/treatment is appropriate; 4) Multiple service/treatment limits not exceeded; 5) Cost of service/treatment appropriate to authorized amount; 7) service/treatment is allowable by service/treatment funding requirements.	3					
F-30	30.015	The system shall support efficient staff maintenance of service/treatment validation tables to assure compliance with local, State and Federal regulations.		3					
F-34	34.001	The system shall be able to update the clinical content or rules utilized to generate clinical decision support reminders and trigger alerts.	Growth charts, CPT-4 codes, drug interactions would be an example. Any method of updating would be acceptable. Content could be third party or customer created.	3		M	H		
F-34	34.002	The system shall be able to update clinical decision support guidelines and associated reference material.	Any method of updating would be acceptable. Content could be third party or customer created.	3		M	H		
F-34	34.003	The system shall be able to initially author and revise clinical practice guidelines.		3					
F-34	34.004	The system shall support linkages between the clinical practice guidelines application and other system modules.		3					
F-34	34.005	The clinical practice guideline module shall be able for rapid documentation of the client's progress through the clinical progress guidelines phases.		3					

F-34	34.006	The system shall provide clinical practice guideline formats that are: Intuitive, easy to use, and user customizable.		3					
F-34	34.007	The system shall support tools to speed up clinical decision support data entry.	Examples are: Pull down menus and check boxes.	3					
F-34	34.008	The system shall support reporting and analysis of any/all components included in the clinical practice guidelines module.		3					
F-34	34.009	The system shall create, review, and update information about performance measures that shall be used to monitor the attainment of objectives, the quantitative and qualitative data to be collected, performance metrics, collection means and origin of data to be evaluated.		3					
F-34	34.010	The system shall allow the provider or other authorized user to override any or all parts of the guideline.		3					
F-34	34.011	Alerts and Clinical Decision Support: The system shall provide advanced alerts and Clinical Decision Support (CDS) based on nationally recognized sources that are updated on a routine basis. The alerts must include: drug alerts, clinical best practices, health maintenance alerts, and disease management guidelines.		3					
F-34	34.011	Evidence-based reference content: The system shall provide advanced, nationally recognized, practice customized clinical reference content with clear labeling of the levels of evidence for facts/assertions and grades of recommendation for recommendations made. These levels and grades are clearly and transparently based on the quality of the underlying evidence using reproducible processes.		3					
F-34	34.012	Alerts and Clinical Decision Support: The system shall provide advanced alerts and Clinical Decision Support (CDS) based on nationally recognized sources that are updated on a routine basis. The alerts must include: drug alerts, clinical best practices, health maintenance alerts, and disease management guidelines.		3					
F-34	34.013	Evidence-based reference content: The system shall provide base line Evidence-based reference content.		3					
F-34	34.014	Evidence-based reference content: The system shall provide advanced Evidence-based reference content by providing links to clinical references which EMR users can then search or browse to find information via nationally recognized Evidence-based medicine.		3					
F-34	34.015	Evidence-based reference content: The system shall provide advanced Evidence-based reference that can be customized to the practice's unique requirements.		3					
F-34	34.016	Evidence-based reference content: The system shall provide advanced, nationally recognized, practice customized clinical reference content with clear labeling of the levels of evidence for facts/assertions and grades of recommendation for recommendations made. These levels and grades are clearly and transparently based on the quality of the underlying evidence using reproducible processes.		3					

F-43	**43.003**	The system shall support critical incident types that are coordinated with triggering administrative alerts.		**3**					
I-05	**5.003**	Clinical Messages: The system shall provide the ability to communicate electronically one–way to the patient via secured email.		**3**					
I-05	**5.004**	Clinical Messages: The system shall provide the ability for 2-way e-messages with the patient.		**3**					
I-05	**5.005**	Clinical Messages: The system shall provide the ability for 2-way e-messages with the patient.		**3**					